OFFICE OF SCHOOL NURSE
7280 Frenchman's Bay
St. Thomas, VI 00802
340-776-1600 x 4603
FAX: 340-776-1019
nurse@antilles.vi

2020-2021

EMERGENCY HEALTH INFORMATION FORM

Information on this form will be shared with school personnel directly involved with your child's education, unless you indicate otherwise.

Student's Last Name: _____ First Name: _____ Middle: _____

Student Usually Called _____

Grade: _____ Date of Birth: _____ Age: _____ Sex: _____

Home Address: _____ Home Phone: _____

Family Physician Name: _____ Physician's Phone: _____

Family Dentist's Name: _____ Dentist's Phone: _____

Emergency Contacts:

First Contact Parent/Guardian:	**Second Contact Parent/Guardian:**
Name: _____	_____
Employer: _____	_____
Daytime Phone: _____	_____
Cell Phone: _____	_____
Email: _____	_____

In case of emergency, if a parent/guardian cannot be reached, notify:

1. _____ Phone: _____

2. _____ Phone: _____

ALLERGIES: Please list ALL allergies including food and drug:

_____

_____

_____

If your child has a health condition(s), which may require EMERGENCY ACTION while at school (e.g., seizures, insect sting allergy, asthma, bleeding condition, sickle cell, diabetes, heart condition, peanut allergy, other), please use the space below to provide detailed information.

_____

_____

_____

_____

_____

Continue on back. Thank you for completing.

Antilles School attempts to discourage distribution of medication while students are at the school. If your physician determines it is necessary for your child to receive prescription medication during the hours your child is in attendance at Antilles, the specific directions and approval accompanied by physician's signature must be provided on the Medication Release Form prior to dispensing of any prescription medication. For your child's safety, it is recommended that first dosage of any medication be administered with the physician or at home.

Please send all medication(s) to the Antilles School Nurse in its original box or bottle with a current prescription label on the container. Pharmacists will assist when necessary to provide a "duplicate" container for this purpose.

_____

2020-2021 School Year

Student's Last Name: _____ First Name: _____ Middle: _____

I/WE hereby grant my/our express permission for the Antilles School Nurse or other School Personnel to administer non-prescription, over-the-counter medication(s) on an as needed basis to my child during the school day for such common ailments as headache, menstrual cramps, fever, rash, etc. (All over-the-counter medications are age appropriate)

*Please check one of the following:

◯ YES, my child can have OTC medications at school (this includes bug spray and sunscreen).

◯ YES, my child can have OTC medications at school with the exception of the following: _____

_____

◯ NO, my child cannot have OTC medications at school.

◯ NO, my child cannot have OTC medications at school, with the exception of hurt-free antiseptic wash and triple antibiotic ointment for cuts in the event of an injury at school.

_____

In the event that I/We am/are unable to be contacted during an emergency situation for my/our child, I/We hereby give my/our express permission for Antilles School to admit my child for emergency treatment to the hospital or other medical facility. I also give Antilles School Nurse or other School Personnel permission to administer Emergency Epinephrine in the form of an Auto-Injector Pen in an allergic emergency/anaphylaxis.

*Please check one of the following:

◯ YES

◯ NO

Parent/Guardian Signature Date Parent/Guardian Signature Date

_____ _____ _____ _____